

Name _____

QUALITY ASSURANCE MONITORING FORM

Osteoporosis

1. Is there evidence of any of the following:
- | | |
|-------------------------------------|--------------------|
| a. Premature birth | _____ yes _____ no |
| b. Long-term immobility | _____ yes _____ no |
| c. History of poor nutrition | _____ yes _____ no |
| d. Evidence of hypogonadism | _____ yes _____ no |
| e. Evidence of menopause | _____ yes _____ no |
| f. Long-term anticonvulsant therapy | _____ yes _____ no |
| g. Prior fractures | _____ yes _____ no |
2. If yes to any of the above:
- a. Is the individual receiving adequate calcium and vitamin D? _____ yes _____ no _____ n/a
- Comments: _____
- b. Has a bone densitometry been done? _____ yes _____ no _____ n/a
- Comments: _____
3. If evidence of hypogonadism/menopause, is a medical work up including hormone levels documented? _____ yes _____ no _____ n/a
- Comments: _____
4. If evidence of hormonal deficiency, has replacement been initiated? _____ yes _____ no _____ n/a
- Comments: _____
5. If evidence of prior fractures or osteoporosis on X-ray or bone densitometry, is the individual on a medication for treatment of osteoporosis? _____ yes _____ no _____ n/a
- Comments: _____
6. If evidence of risk for or presence of osteoporosis, is the individual a candidate for participation in a weight bearing exercise program? _____ yes _____ no _____ n/a
- Comments: _____

RECOMMENDATIONS: _____

SIGNATURE _____

DATE _____